# CENTRAL CAROLINA KIDNEY ASSOCIATES, P.A.

WIF/WIFS/WIS/DF	First	Middle		Last	
Address	Street	City	;	State	Zip
Birthday		Age	_ SS#		
Email address:					
Primary Phone (	)	Alternate P	hone (	)	
Patient's Employer				_ □Not E	mployed □Retired
Patient's Marital Sta	atus (circle) S / M	/ Div. / Wid. / Partr	ner		
*Name of spouse/par	tner				
Referring or Primar	y Physician:				
Please list an <b>EMER</b>	GENCY CONTAC	т			
Contact name	nt.: □Spouse □(	F Child □Parent □	hone Num Friend □	nber INeighbor	□Other
authorize CCKA to ny insurance compan yees during my treatm najor medical benefit lans to: CCKA.	y to whom I have ent with CCKA. I	submitted claims. hereby assign all	I underste medical a	and I am i nd/or surg	responsible for all n gical benefits, to inc
Signature of Respor	nsihle Party			Dat	te

PROVIDE INSURANCE CARD SO WE MAY RETAIN A COPY TO FILE YOUR INSURANCE

# CENTRAL CAROLINA KIDNEY ASSOCIATES, P.A.

#### PATIENT ACKNOWLEDGMENT AND CONSENT

I have read a copy of Central Carolina Kidney Associated that a copy is available disclosures of my health information as outlined in	e to me to take home. I consent to the uses and
Signature of Patient or Representative	Date
Print Name	Relationship of Representative to Patient
Please describe the Representative's authority to act	on behalf of Patient:
FOR Central Carolina Kidn	nev Associates LISE ONLY
If acknowledgment of receipt of the Notice of Privac patient's representative, please explain your efforts t not obtain it:	cy Practices is not obtained from the patient or the

2903 Professional Park Drive Suite D Burlington, North Carolina 27215 Phone: 336-584-4913

# CENTRAL CAROLINA KIDNEY ASSOCIATES, P.A.

#### CONSENT FOR RELEASE OF

#### PROTECTED HEALTH INFORMATION TO FAMILY<sup>1</sup>

I consent to disclosure of the following protection involved in my care or payment for my care:	cted health information (PHI) about me to the person(s)				
	ma				
NAM	ES				
Check all that may apply (to be released to a	above individuals):				
☐ All my medical information					
☐ Information necessary to schedule appointments for me					
☐ Lab or test results					
☐ Information necessary to provide, call in or pick up prescriptions for me					
☐ Information necessary to help my family	member(s) take care of me				
<ul> <li>Information necessary to allow my famil</li> </ul>	ly member(s) to pick up or arrange for medical				
equipment to be provided for me					
☐ Information necessary to bill for or submit claims for care provided to me to government or					
private insurance payors					
My consent will remain in effect as long as	s I am a patient of Central Carolina Kidney Associates, PA				
(CCKA) unless and until I notify CCKA in writing of	<sup>:</sup> any changes.				
Signature of Patient or Representative	Date				
Print Name	Relationship of Representative to Patient				

2903 Professional Park Drive Suite D Burlington, North Carolina 27215 102 Medical Park Drive Suite C Mebane, North Carolina 27302

1352 West Harrison Street Reidsville, North Carolina 27320

Phone: 336-584-4913 Web Site: www.centralcarolinakidney.com